MOTION FILED

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No. 98-1949

IN THE

Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF WASHINGTON LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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Date: July 28, 1999

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MOTION FOR LEAVE TO FILE BRIEF OF WASHINGTON LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37.2 of the Rules of this Court, the Washington Legal Foundation respectfully moves for leave to file the attached brief as *amicus curiae* in support of Petitioners. Petitioners have consented to the filing of this brief; their letter of consent has been lodged with the Clerk of the Court. Respondent has declined to consent, thereby necessitating the filing of this motion.

The Washington Legal Foundation (WLF) is a non-profit public interest law and policy center with supporters nationwide, including many in Illinois. While WLF engages in litigation and participates in administrative

proceedings in a variety of areas, WLF devotes a substantial portion of its resources to advancing the interests of the free-enterprise system and to ensuring that economic development is not impeded by excessive litigation. To that end, WLF has appeared before this Court as well as other federal and state courts in cases raising tort liability issues arising under the Employee Retirement Income Security Act of 1974 (ERISA). *See, e.g., Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). WLF also has appeared in cases touching upon the effects of tort liability on the ability of health care providers to deliver quality service to the American public. *See, e.g., Rotella v. Wood,* No. 98-896 (decision pending, U.S. S.Ct.); *Medtronic, Inc. v. Lohr,* 116 S. Ct. 2240 (1996).

WLF is concerned by the proliferation of suits against health maintenance organizations (HMOs) and their fiduciaries being brought pursuant to ERISA. WLF believes that such suits have the potential -- particularly when, as here, they are directed at physicians' individual treatment decisions -- to cause serious disruption to the delivery of quality, affordable health care.

WLF fully agrees with Petitioners both that the appeals court's decision misinterpreted ERISA and that -- by extending ERISA fiduciary responsibilities to encompass cost-containment mechanisms -- it will undermine efforts to ensure that quality health care is widely available at affordable costs. WLF is filing separately in order to emphasize the pernicious effects of one aspect of the appeals court decision: the holding that *physicians'* treatment decisions are also subject to ERISA standards. That holding will directly undermine medical care; by decreeing that treating physicians owe a fiduciary duty to the plan *as a whole,* the holding diverts physicians from their state-law

responsibility to focus on the treatment needs of individual patients.

WLF is filing this brief because of its interest in maintaining high-quality health care to all Americans. It has no interest in the outcome of this lawsuit or of any other suits raising similar issues. Because of its lack of direct economic interests, WLF believes that it can assist the Court by providing a perspective that is distinct from that of any party.

For the foregoing reasons, WLF respectfully requests that it be allowed to participate in this case by filing the attached brief.

Respectfully submitted,

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QUESTION PRESENTED

Whether a health maintenance organization (HMO) and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1104(a)(1), by implementing a managed care program in which the physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

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BRIEF OF WASHINGTON LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*

The interest of *amicus curiae* Washington Legal Foundation is set forth in the motion accompanying this brief.[1]

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[1] Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amicus*, contributed monetarily to the preparation and submission of this brief.

STATEMENT OF THE CASE

The *amicus* incorporates the Statement of the Case in the Petition for Writ of Certiorari and briefly summarizes the identities of the parties and the decision of the United States Court of Appeals for the Seventh Circuit.

Respondent Cynthia Herdrich received medical treatment through an HMO. Petitioners are the physician (Dr. Pegram) who provided treatment to Ms. Herdrich, the operator of the HMO (Health Alliance Medical Plans, Inc. or "HAMP"), and HAMP's owner (Carle Clinic Association or "Carle Clinic").

The physicians who provide services to patients covered by the HMO own Carle Clinic, which is the sole shareholder of HAMP. HAMP received a fixed amount per patient to provide services to HMO patients. Thus, the less money expended on patient care, the better HAMP's short-term financial return. In turn, the more money that HAMP and the Carle Clinic made, the larger the financial reward to the physicians who provided services to HMO patients. This compensation scheme can be viewed as providing either of two incentives. It may encourage physicians to provide diagnosis and treatment at the earliest possible stage in the hope of keeping long-term costs down and profits up, or it may encourage physicians to skimp on current treatment in the hope of driving short-term profits up. The Court of Appeals, reviewing a ruling on a motion to dismiss the complaint, accepted the Respondent's allegation that the second incentive governed the medical judgment at issue.

This case arose because Dr. Pegram misjudged the urgency of Ms. Herdrich's need for medical treatment.

Instead of sending Ms. Herdrich to the emergency room for an immediate sonogram to determine whether an appendectomy was required, Dr. Pegram chose a cheaper option, scheduling the sonogram for a later date at a different facility. Choosing the cheaper option reduced the short-term cost of providing care to Ms. Herdrich, thereby enhancing the financial return to HAMP and Dr. Pegram.[2]

The Court of Appeals concluded that the Carle Clinic and HAMP were fiduciaries under ERISA because they had the right to decide disputed claims of individuals covered by the HMO. *Herdrich v. Pegram*, Pet. App. 14a. Dr. Pegram was a fiduciary because she exercised discretion in rendering care to individuals covered by the HMO. *Id.* at 19a. The Court of Appeals further found that the financial incentives under which Dr. Pegram operated as a fiduciary could give rise to a fiduciary breach where, as alleged by the Respondent, a physician delays or withholds care to benefit herself financially. *Id.* at 20a.

REASONS FOR GRANTING THE PETITION

Amicus fully supports the Petitioners' reasons for granting the petition. The Court of Appeals' decision could severely disrupt the ability of employer-sponsored plans to deliver care in a cost-effective manner, interfering

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[2] In retrospect, of course, it would have been far cheaper for all of the Petitioners if Dr. Pegram had chosen the more expensive emergency room option, thereby avoiding the cost of treating Ms. Herdrich's peritonitis. Similarly, the sensible response of employers whose employees receive the type of treatment that Ms. Herdrich received is to change HMOs. Thus, while discounted by the Court of Appeals, market forces should keep HMOs from skimping on care for short-term gains.

with the operation of a significant segment of the economy and the health care coverage of a large percentage of the population.

In 1997, the last year for which data are available from the Health Care Financing Administration, Americans spent $1.1 trillion on health care or 13.5% of the gross domestic product, and experts predict national health spending will rise to $2.1 trillion by the year 2007. Sheila Smith et al., *The Next Ten Years of Health Spending: What Does the Future Hold*, Health Affairs, Sept./Oct. 1998, at 128-29. Nearly two-thirds of health insurance coverage is provided through employer-sponsored plans. Employee Benefit Research Institute, *EBRI Databook on Employee Benefits* 211 (4th ed. 1997).

The Court of Appeals' decision not only threatens the operation of these health plans, it also could interfere with the delivery of services at the patient level. This is because the Court of Appeals reached the remarkable conclusion that a physician may become a fiduciary under ERISA by exercising discretion in providing patient care. This, in turn, would subject the physician's individual treatment decisions to ERISA's fiduciary standards -- standards wholly unsuited to regulate patient care.

The purpose of health plans is to provide a means of paying for the treatment provided by physicians, nurses, and other health care professionals. The plans that serve as this payment mechanism are subject to ERISA, which requires that the persons responsible for the administration of a plan act prudently in the management of the plan's assets and the conduct of the plan's business under a framework of rules largely drawn from private trust law.

The Court of Appeals, intent on eliminating financial incentives it viewed as inconsistent with good patient care, decided to superimpose ERISA's rules designed to govern the relationship between trustee and beneficiary to a wholly different relationship, that of doctor and patient. By doing so, the Court of Appeals has applied a legal regimen designed to regulate the investment of trust assets to a physician's treatment decisions made in the ordinary course of patient care. It is difficult to imagine a more unsuitable application of rules designed to govern one set of behaviors to conduct of a wholly different character and purpose. By confusing paying for treatment with the treatment itself, the Court of Appeals has created a legal quagmire that will substantially upset the operation of the nation's health care system and subvert the standard of care that physicians owe to their patients.

The Court of Appeals' decision impacts nearly 10% of the economic activity of this country by imposing on the practice of medicine a regulatory regime that was never designed for, and is plainly not suited to, that purpose. Moreover, the imposition of fiduciary status and resulting regulation under ERISA could spill over to lawyers, teachers, and others who provide professional services paid for through ERISA plans. The Court should grant review of the decision to prevent such a misguided and dangerous outcome.

I. THE MISAPPLICATION OF ERISA TO PHYSICIANS' TREATMENT DECISIONS WILL UNDERMINE THE PROVISION OF QUALITY HEALTH CARE UNDER ERISA PLANS.

A person is a fiduciary under ERISA to the extent the person exercises any discretionary authority or discre-

tionary control respecting management of the plan or exercises any authority or control respecting management or disposition of the plan's assets or has any discretionary authority or discretionary responsibility in the administration of the plan. ERISA § 3(21)(A).

Those who fall under the definition of ERISA fiduciary must carry out their duties with respect to a benefit plan solely in the interest of the plan's participants and beneficiaries, for the exclusive purpose of providing benefits and defraying reasonable administrative costs, in a prudent manner and in accordance with the documents and instruments governing the plan. ERISA § 404(a)(1)(A), (B), (D); 29 U.S.C. § 1104(a)(1)(A), (B), (D). To meet these duties, fiduciaries must consider the interests of the participants and beneficiaries of the benefit plan as a whole, not the interests of any one participant. *See Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996) ("a fiduciary obligation...does not necessarily favor payment over nonpayment. The common law of trusts recognizes the need to preserve assets to satisfy future as well as present claims and requires a trustee to take impartial account of the interests of all beneficiaries."). For this reason, an ERISA fiduciary does not breach his or her fiduciary duty by denying a benefit claim for services that are not covered under the benefit plan, even though the services may be appropriate as a matter of medical judgment. *E.g.*, *Martin v. Blue Cross and Blue Shield of Virginia*, 115 F.3d 1201, 1209 (4th Cir.), *cert. denied*, 522 U.S. 1029 (1997) (health plan participant not entitled to payment for treatment recommended by her physician but not covered under health plan).

In contrast to ERISA fiduciaries, physicians, by virtue of state law, are held to a standard of care to the individual

patient. A physician is required to recommend appropriate treatment based on the patient's interest. *See, e.g., Addison v. Whittenberg*, 529 N.E.2d 552, 556 (Ill. 1988). Thus, subjecting physicians' treatment decisions to ERISA standards, which are designed to ensure plan integrity, will not enhance medical care. At best, applying ERISA standards to physicians will add an unnecessary layer of regulation and at worst could undermine physicians' ability to provide quality care to their patients.

The Court of Appeals' decision permits this perverse result. As described in the decision, a physician's exercise of discretion in prescribing a particular course of treatment may make the physician a fiduciary under ERISA. *Herdrich v. Pegram*, Pet. App. 19a, 20a. If the physician's compensation through an ERISA-covered plan is affected by the care he or she prescribes, ERISA would require the physician, as a fiduciary of the plan, to temper his or her decisions regarding the appropriate treatment for individual patients by taking account of the financial impact a particular treatment recommendation may have on the plan as a whole and on the plan's participants as a group. Thus, a physician burdened with the mantle of ERISA fiduciary could rightly decide under ERISA to withhold expensive treatment from a near-terminal patient in order to conserve scarce resources for the benefit of the healthier majority of plan participants. These non-medical, financial considerations are the very essence of what the Court of Appeals thought should *not* influence physicians at the treatment level. *Id.* at 31a ("doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients.").

Moreover, the effect of the Court of Appeals' decision is not limited to doctor-owned HMOs, like the one the

Court of Appeals considered. The exercise of medical judgments almost always has direct or indirect financial consequences to the treating physician. Under traditional fee-for-service arrangements, for example, doctors exercise discretion in making treatment decisions. Virtually all of these treatment decisions have financial ramifications because the doctor determines the treatment that he or she will perform and be paid for. *See* Lee Holleman et al., *Are Ethics and Managed Care Strange Bedfellows or a Marriage Made in Heaven?*, 349 Lancet 350 (1997) ("In the fee-for-service system, however, physicians had an intrinsic incentive to overtreat, which contributed to the high incomes of doctors and the high cost of health care but not necessarily to better outcomes.").

In addition to affecting their direct compensation through their treatment decisions, doctors also can affect their compensation by prescribing diagnostic tests to be performed by laboratories in which they own an interest. Bruce J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice - A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 New Eng. J. Med. 1604 (1990). Unlike the incentives imposed by managed care, these types of incentives may lead to excessive testing and procedures, which can be equally as harmful to a patient as withholding treatment. Peter Franks et al., *Gatekeeping Revisited - Protecting Patients from Overtreatment*, 327 New Eng. J. Med. 424 (1992). The financial incentive to provide unnecessary services reduces the quality of care by subjecting participants to excessive

testing and procedures.[3] If, as the Court of Appeals determined, the existence of financial incentives that could adversely influence a physician's medical judgment gives rise to a fiduciary breach, then even traditional fee-for-service arrangements, when funded through an ERISA-covered plan, could give rise to a fiduciary breach.

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[3] Numerous studies have consistently found that capitation-fee arrangements incur lower costs than fee-for-service arrangements with quality equal to or better than fee-for-service care. *See* Peter Franks et al., *Gatekeeping Revisited - Protecting Patients from Overtreatment*, 327 New Eng. J. Med. 424 ("Several authors have expressed concern that primary care physicians whose income is directly linked to the extent to which they limit the use of resources may undertreat patients. Although this market view of physicians' behavior is plausible, there is little empirical evidence that primary care physicians withhold beneficial care for financial reasons," and the Rand Health Insurance Experiment revealed that inappropriate surgery was selectively reduced in capitation arrangements.); Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 New Eng. J. Med. 1227 (1996) ("If anything, the data suggest hazards and ethical problems in the overuse of services in fee-for-service settings, rather than its underuse in capitated care."); David A. Durfee, *Capitated Care is Ethical*, Archives of Ophthalmology (Sept. 1997) ("To suggest that a particular physician functions ethically under a fee-for-service system but not under capitation is inaccurate. The reality is 'good' physicians function well in either environment; 'bad' physicians do poorly under both systems of reimbursement."); *see also* R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Health Care*, 76 Milbank Q. 649 (1998).

II. THE COURT OF APPEALS' DECISION COULD IMPROPERLY SUBJECT OTHER TYPES OF PROFESSIONALS TO ERISA'S FIDUCIARY STANDARDS, UNDERMINING THE QUALITY OF PROFESSIONAL SERVICES PROVIDED UNDER ERISA PLANS.

Professional services other than medical care are funded through ERISA plans, and the Court of Appeals' decision could turn professionals exercising discretion in providing services to individuals covered by these plans into ERISA fiduciaries, also. This, in turn, would subject the professionals' conduct to ERISA's fiduciary standards. Just as ERISA's fiduciary standards are the wrong measure for judging medical care, ERISA's fiduciary standards similarly do not provide an appropriate measure for judging the services provided by lawyers, counselors, teachers, and other professionals whose services are paid for through employee benefit plans. More significantly, using ERISA standards to judge these professional services could interfere with the exercise of professional judgment in individual cases, reducing the quality of professional services that participants receive under ERISA plans.

Pre-paid legal services, for example, may be funded through ERISA plans. ERISA § 3(1); 29 U.S.C. § 1002(1). The services are provided pursuant to contracts with law firms or particular attorneys, usually based on a flat fee per participant or per type of project. Because these arrangements do not compensate attorneys based on the time they spend on a project, attorneys have a financial incentive to spend as little time on a project as possible. Attorneys in this situation exercise the same type of discretion as Dr. Pegram in deciding what course of action to recommend to a client. Under the Court of Appeals'

reasoning, this would make them fiduciaries of the legal services plan. And like Dr. Pegram, lawyers providing services to plan participants would in many cases own their firm or stock in the professional corporation, giving them an incentive to withhold services to enhance their financial return.

Codes of conduct and malpractice standards that apply to attorneys require them to consider the interests of clients, not their own financial interests, in providing legal advice. If an attorney or firm gives a participant bad legal advice, the participant's recourse against the attorney or firm is a malpractice action under state law. The Court of Appeals' decision, however, would give the participant a claim for breach of fiduciary duty under ERISA.

Under the Court of Appeals' reasoning, an attorney who provides legal advice under an arrangement that creates a financial incentive to skimp on services or otherwise fail to provide the highest quality services could be deemed to have breached fiduciary duties. This, in turn, would subject the attorney's *legal judgments* to ERISA's fiduciary requirements. ERISA's standards, however, with their emphasis on ensuring plans' financial integrity, are no better suited to regulate legal services than medical care.

Other types of professional services funded through ERISA plans include counseling services under employee assistance programs, on-site day care, outplacement services, and apprenticeship training. ERISA § 3(1); Department of Labor Advisory Opinion ("DOL Adv. Op.") 83-35A (June 27, 1983); DOL Adv. Op. 91-26A (June 9, 1991); DOL Adv. Op. 97-12A (April 18, 1992). Counselors, social workers, and teachers providing services

under these plans exercise discretion in providing services to individual plan participants, which, under the Court of Appeals' decision, could make these professionals pian fiduciaries. To the extent the plans' contractual arrangements with professionals create financial incentives that could influence the professionals' judgment in providing services, then the advice provided by the professionals could give rise to a fiduciary breach.

ERISA's standards, however, simply do not provide an adequate substitute for, much less an improvement over, the legal and ethical constraints that already regulate professionals such as physicians, attorneys, counselors, and teachers under state law. The fact that services performed by these professionals are paid for through the mechanism of an employee benefit plan subject to ERISA should not change the standards that apply to their exercise of professional judgment. Changing the standard would have the perverse result of lowering the quality of care provided under ERISA-covered plans, especially health plans.

Left unchanged, the Court of Appeals' decision threatens the operation of the country's health care system both at the plan level, as described by the Petitioners, and at the individual patient level. To avoid these misguided effects, the Court should review the decision.

CONCLUSION

Amicus curiae Washington Legal Foundation respectfully requests the Court to grant the Petition.

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